MDR Tracking Number: M5-04-2613-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on April 19, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The office visits and therapeutic exercises from 05-13-03 through 05-19-03 **were** medically necessary. The office visits and therapeutic exercises from 05-20-03 through 08-25-03 **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-12-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
05-19-03	97750-MT	$43.00	$0.00	G	$43.00	1996 Medical Fee Guideline Rule 133.307(e)(2)(A)	The carrier denied 97750-MT as Global. However, according to the 1996 Medical Fee Guidelines, global fees only apply to surgical procedures (per Ground Rules). Therefore recommended reimbursement of $43.00
06-16-03	97750-MT	$43.00	$0.00	G	$43.00	1996 Medical Fee Guideline Rule 133.307(e)(2)(A)	The carrier denied 97750-MT as Global. However, according to the 1996 Medical Fee Guidelines, global fees only apply to surgical procedures (per Ground Rules). Therefore recommended reimbursement of $43.00
06-16-03	99213 97110 x5	$48.00 $175.00	$0.00	No EOB	$48.00 $35.00 x5	1996 Medical Fee Guideline	The requestor submitted convincing evidence of carrier

						Rule 133.307(e)(2)(A)	receipt of the provider's request for EOB's. Therefore, recommend reimbursement of $48.00 for CPT code 99213. See rationale below for CPT code 97110.
07-03-03	99213 97110 x5	$48.00 $175.00	$0.00 $0.00	No EOB	$48.00 $175.00	1996 Medical Fee Guideline Rule 133.307(e)(2)(A)	The requestor submitted convincing evidence of carrier receipt of the provider's request for EOB's. Therefore, recommend reimbursement of $48.00 for CPT code 99213. See rationale below for CPT code 97110.
08-18-03	99213-QU	$62.81	$59.57	F	$66.19	Medicare Fee Schedule Rule 133.307 (e)(2)(A)	The requestor did not submit a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with Rule 133.304 for services rendered 08-18-03. Therefore no additional reimbursement recommended.
08-28-03	99080-QU	$18.50	$0.00	G	Unable to determine without recon HCFA	Medicare Fee Schedule Rule 133.307 (e)(2)(A)	The requestor did not submit a copy of all medical bills as originally submitted to the carrier for reconsideration in accordance with Rule 133.304 for services rendered 08-28-03. Therefore no additional reimbursement recommended
TOTAL							The requestor is entitled to reimbursement of $182.00.

Rationale for CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair

and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 05-13-03 through 07-03-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 5th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

June 9, 2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-2613-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent

review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on the job on ___ by performing repetitive lifting. She was treated by Dr. S and referred to Dr. K for rehabilitation. A MRI revealed bowing on the flexor retinaculum and increase signal intensity in the median nerve indicating likely carpel tunnel syndrome. There was also evidence of a complex TFCC tear. A NCS/EMG demonstrated increased insertional activity in the abductor pollicus brevis and slowing of the sensory component of the median nerve indicating early findings of left carpal tunnel syndrome. She had pre-surgical rehabilitation that failed to resolve the complaint. A carpal tunnel release was performed on 3-11-2003. Rehabilitative therapies resumed on 3-24-2003 on a frequency of four times per week through 4-03-2004. The frequency then reduces to three times a week while the continues to recommend four time per week. This continued through 7-10-2003 until she was seen weekly or more frequently.

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of level III office visits and therapeutic exercises.

DECISION

The reviewer disagrees with the previous adverse determination regarding the dates of service from 5-13-2003 through 5-19-2003. However, the reviewer agrees with the previous adverse determination regarding the dates of service from 5-20-2003 through 8-25-2003.

BASIS FOR THE DECISION

According to Maxey and Magnusson, Rehabilitation for the Postsurgical Orthopedic Patient, pages 106-116, it is reasonable to expect treatment for six weeks postoperatively to be extended to twelve weeks with significant improvement with controlled pain and increased range of motion. It appears that ___ had not recovered well and progressed very slowly with treatment beyond 5/6/03. No chiropractic or orthopedic evaluations were performed after 4/21/03. No significant change in treatment plan or improvement of subjective/objective symptomatology is noted beyond 5/20/03. Secondly, there were no examinations to justify further care. Mercy Treatment and Rand Consensus Guidelines allow treatment at four week intervals with re-evaluations to justify continuance of care if there is significant improvement or if there are complicating factors. The reviewer indicates the documentation does not indicate improvement nor objective indications of patient improvement.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,